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Access Through Medical Interpreter and Language Services (ATMILS): Research Findings and Recommendations

New York Task Force on Immigrant Health

New York University School of Medicine
Division of Primary Care

Bellevue Hospital Center

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I. About the ATMILS Project

The Impact of Language Barriers on the Health of Immigrant Populations

According to the 1990 census, 2.8 million New York City residents speak a language other than English at home.[1] Health care facilities employ a number of strategies to bridge the language gap when treating a foreign-born, limited English-speaking population. The majority of medical interpretation, when available at all, is provided by untrained bilingual staff members, volunteers, other patients, and family members, including children. These strategies can result in miscommunication between the provider and the patient, violate confidentiality, disempower non-English speaking patients, and raise serious ethical and legal issues.

The failure of health care facilities to provide culturally and linguistically appropriate services has considerable costs, both medical and financial. The consequences of miscommunication, such as diagnostic errors, missed appointments, the failure of patients to understand and adhere to treatment recommendations, the failure of providers to obtain truly informed consent and to be sensitive to a patient's own culturally derived understanding of health and illness, can be costly and severe. Indirect costs can also result from decreased physician productivity, lack of patient adherence, and the ordering of unnecessary tests. Non-adherence to medical treatment and poor follow-up for tuberculosis and other infectious diseases have been found to be exacerbated by cultural and language barriers.[2] A 1988 study of asthmatics found that language concordance between patients and providers was a significant factor in achieving optimal medication adherence and improved office attendance.[3] The implications of this finding are considerable, particularly when communicable diseases are at issue. Substandard or lack of interpreter services carry significant public health costs, which may not be readily apparent to health care planners and administrators.[4] If, as this study suggests, limited-English proficient (LEP) patients are considerably less likely to seek preventive health care when interpreter/language services are not made available, the lack of widespread interpreter services poses a serious public health threat.

There are federal and, in some cases, state legal mandates for the provision of interpreter services. However, they are rarely enforced. In the absence of formal interpreter programs, limited English and non-English speaking persons are unable to make informed decisions about their health care.

In response to the widely unmet need for interpreter services, an increasing awareness of the potential legal implications of failing to provide such services, and in the face of steadily growing immigrant populations around the country, health care facilities in selected cities began to hire and train bilingual individuals to serve as full-time interpreters. They were not certain that the establishment of interpreter programs would be financially sound

endeavors. In many cases, an underlying commitment to meeting the needs of under-served communities compelled them to do what was necessary to reduce linguistic and cultural barriers to health care. The primary impetus for the development of interpreter programs, however, was the threat, either real or perceived, of legal action. Once interpreter services were established, health care facilities learned that the initial expenses paid off financially. While interpreter services were not viewed initially as a marketing tool, once initiated, they helped facilities to capture a large share of an ethnic community. This did not go unnoticed by hospital administrators.[5] As communities increasingly began to identify a particular facility as "their community's facility," many institutions saw their volume of paying and insured non-English speaking patients increase dramatically.

While medical interpreter and language services systems have been developed in selected areas of the country, no overarching medical interpretation system exists for New York City. The New York City Health and Hospitals Corporation (HHC) concluded that those who serve as interpreters must be adequately screened in both their languages and for their ability to perform effective interpretation.[6] However, there is currently no system in place in New York City by which to implement this conclusion, or by which to train sufficient numbers of bilingual individuals in medical interpretation.

Access Through Medical Interpreter and Language Services: Project Overview

In response to the widespread lack of interpreter services, the New York Task Force on Immigrant Health developed a medical interpreter project entitled, "Access Through Medical Interpreter and Language Services (ATMILS)." This project strives to increase access to medical services for non-English speaking populations. Its ultimate goal is the creation of a comprehensive medical interpreter network in New York City. The first phase of the project consisted of an analysis of established medical interpreter programs across the country to: a) identify the best features of each program, and b)determine the feasibility of replicating these features in New York City. In the Fall of 1995, site visits were conducted in the following states: California (Los Angeles, Oakland, San Diego, San Francisco), Illinois (Chicago), Massachusetts (Boston, Worcester), and Minnesota (Minneapolis/St. Paul). In addition, telephone interviews were conducted with sites in Florida and Washington. (See Appendix A for complete list of sites visited.)

Following the nationwide interpreter program review, the Task Force initiated a language needs assessment of New York City health care facilities to evaluate the issues to be addressed in the establishment of a citywide medical interpreter system. Individuals most directly involved with the provision of interpreter services (volunteer coordinators, patient representatives, administrators) were interviewed about their facilities' approaches to addressing the needs of limited-English speaking patients.

The following factors were assessed:

- Linguistic service needs of patients
- Position of hospital administration with regard to language services
- Current strategies used to address language needs of patients
- Organization of interpreter services within health care facility structure
- Methods of screening and training interpreters (if any)
- Methods of financing existing interpreter services

The national model analysis and the New York City assessment led to the development and implementation of an interpreter training curriculum and course. Bilingual health care workers, volunteers and immigrant community members are being trained by the Task Force in: a) the role and responsibilities of the interpreter, b) the practice of medical interpretation, c) medical vocabulary, d) the interpreter's code of ethics, and e) recent changes in immigrant health care entitlements. ATMILS will create a regionally-centralized pool of trained interpreters.

About this Report

The field of medical interpretation has a relatively short history in the United States. While notable efforts are underway in selected areas of the country, medical interpretation has not yet achieved the stature or widely acknowledged importance of other forms of interpreting (e.g. court, conference, ASL). It is the goal of this report, and of the ATMILS project as a whole, to stimulate discussion, information sharing, and program development which will enhance the ability of limited and non-English speaking persons to obtain quality health care services. The Task Force analyzed notable efforts around the country which are designed to address the great need for medical interpreter services. These can serve as models for similar efforts to come. This report reflects the facts at the time the research was conducted. Individual facilities' programs may have changed by the time of publication. Interpreter services directors should be contacted for information concerning program changes. A list of all sites visited can be found in the Appendix.

II. Legal Mandates for Linguistic Access in Health Care Settings

The need for interpreter services has been recognized in state and federal legislation. Several states, including New York, have imposed legal obligations on health care facilities to provide some level of language services. But there is a large gap between what is mandated and what linguistic services are actually delivered. In general, states with the most specific requirements and mechanisms for their enforcement, tend to provide the most comprehensive services. This section will provide an overview of federal, state, and local legislation on linguistic access in health care settings, with a consideration of the changing context of health care delivery and its impact on linguistic service delivery.

Federal Laws

The Department of Health and Human Services views the failure of government-funded health care facilities to provide interpreter services as a form of discrimination. Title VI of the Civil Rights Act of 1964 bars institutions which receive government funds from engaging in discriminatory practices or those which have a discriminatory impact, based on "race, color, or national origin."[7] Federal court cases in the areas of education and social services have ruled that language is an essential component of national origin, and the Office of Civil Rights has confirmed their applicability to health care. Access to a public facility, therefore, cannot be denied or hindered based on language alone. The Civil Rights Act also provides for appropriate remedies, such as corrective action orders and possible compensatory and/or punitive damages. According to the law, if health care facilities are found to be noncompliant, they also risk losing Medicaid and Medicare reimbursement.

Despite the fact that most health care facilities receive federal funds and are, therefore, bound by these regulations, enforcement of linguistic access requirements has been difficult. Office of Civil Rights investigations are largely complaint-driven. Few limited or non-English speaking persons are aware of their right to an interpreter, or are empowered enough to demand one. Because complaints are rarely made, there is little incentive for hospitals to hire and train interpreters. In most cases, hiring a few bilingual clerks is considered adequate protection against a potential civil rights complaint. The vague language of the legislation provides no guidelines on what constitutes "appropriate language services." Moreover, there are not adequate funds to ensure that interpreter programs are implemented.

The Department of Health and Human Services does investigate complaints of discrimination by limited English proficient individuals who are denied such services. While actual case law in this area (i.e. lawsuits which resulted in the payment of compensatory

and/or punitive damages and a mandate to establish interpreter services) is lacking, several complaints to the Office of Civil Rights (OCR) have prompted hospital-based interpreter programs. These include programs in Massachusetts, California, Washington, and Florida. Yet, because these complaints have only subjected the parties directly involved to the mandated remedies, they have not been able to establish precedents which can be broadly applied on a state or federal level.

Washington State's use of Title VI demonstrates that a combination of community-based advocacy efforts, legal pressure, and aggressive OCR enforcement can lead to the development of comprehensive interpreter services. A large influx of immigrants and refugees to the Seattle area in the 1970s saw hospitals overwhelmed with limited-English speaking patients. These hospitals began to rely on community-based organizations for assistance in meeting their language needs. The situation became increasingly insupportable, as these agencies were not being reimbursed for their services. Subsequent discussions between the C.B.O.s and area hospitals to negotiate a mutually acceptable response to the problem were unsuccessful. In 1981, collaboration between local ethnic community leaders, a legal aid organization, and the regional OCR led to the filing of complaints on behalf of three different clients at three different facilities. Several months later, negotiations led to a settlement in which 10 Seattle hospitals contracted with a language bank operated by several community clinics. This centralized interpreter service today provides 24-hour interpretation in over 30 languages to 22 area hospitals, as well as to a number of social service agencies and community clinics.

The factors leading to the development and sustainability of Washington's model interpreter services were a recognition of the problem by health care providers and community organizations serving immigrant and refugee populations; a willingness to challenge the standard operating procedures at local hospitals; the strong support of the legal advocacy community, and the ongoing involvement of the regional Office of Civil Rights and its determination to enforce the law.

State Laws

A handful of states have enacted legislation with more detailed requirements for linguistic access. In a few cases, this has occurred in direct response to the threat of legal action. In some states, such rights are only extended to a patient population which meets a minimum numerical threshold of the facility's entire patient population. In states with the most comprehensive interpreter legislation (California, Washington, and Illinois), the development of interpreter services came as a direct result of lobbying and/or the threat of legal action by advocacy groups and community organizations. Such tactics, then, serve as important catalysts for the development of interpreter services. But, just as the federal legal mandates for medical interpreter services do not not guarantee the provision of these services,

nor do they on the state level. Moreover, state laws pertaining to language access are notoriously vague in their language, particularly regarding enforcement. For example, New York State law section 405.7, Official Compilation of Codes, Rules, and Regulations, states that "hospitals shall manage a resource of skilled interpreters and persons skilled in communicating with vision and hearing impaired individuals and shall provide translations/ transcriptions of significant hospital forms, instructions and information in order to provide effective visual, oral, and written communication with all persons receiving treatment in the hospital regardless of a patient's language or impairment of hearing or vision."[8] Yet this legislation fails to define the specifics of the requirement or of its enforcement, and New York City lags far behind other large urban areas in its determination to provide comprehensive, quality interpreter services.

The availability of funding for interpreter services under Medicaid also varies by state. In New York, for example, reimbursement for interpreter services has been included, since 1978, in the medical assistance program rate structure, "Schedule Y," as part of miscellaneous administrative overhead. Hospitals exercise their discretion on how that rate is applied, but it is rarely allocated for interpreter services. Only one state (Washington) explicitly offers reimbursement through Medicaid for facilities providing interpreter and language services. Otherwise, funds for language services are generally taken from hospital auxiliary funds.

Managed Care and Linguistic Access Requirements

The overhaul of the health care delivery system (especially Medicaid) from fee-for-service to managed care holds great significance for immigrant and refugee populations, particularly given their special health access needs. A 1994 study by the Association of Asian Pacific Community Health Organizations (AAPCHO) anticipates three broad ways in which managed care will adversely affect health care delivery to minority groups: 1)the complexity of the enrollment process will not be grasped by those unfamiliar with managed care systems; 2)the lack of staff with adequate language and cultural competency skills in managed care facilities will lead to inadequate service for ethnic populations; and 3)managed care's emphasis on cost efficiency will obstruct investment in the supplementary services needed by the population, such as education and interpretation.[9] The drafting of managed care legislation represents an important opportunity to codify explicit language access requirements outside the framework of federal civil rights laws.

As mandatory Medicaid managed care appears to be imminent, there are a number of areas of concern for persons with no or limited English-speaking abilities. Among these is the ability of prospective enrollees to make informed decisions when selecting a plan, without coercion, slick marketing techniques, financial incentives, and/or false information. A 1995 study by New York City's Office of the Public Advocate revealed that managed care

organizations routinely engage in misleading marketing techniques. One plan routinely distributed a Medicaid marketing flier claiming that it's plan was ranked first despite the fact that the survey on which it was based was limited to a particular plan for which Medicaid recipients were not eligible.[10] The Public Advocate's study showed that managed care organizations regularly presented their Medicaid and commercial plans as being equivalent, even though Medicaid plan holders have far fewer primary care physicians from which to choose. While restrictions on marketing and enrollment practices have emerged in the wake of such misinformation, limited English-speaking persons remain particularly vulnerable to the dubious claims advanced by many managed care plans vying for new customers.

To protect individuals, monitoring and regulatory measures that pertain directly to informed consent during enrollment have been developed. States have tremendous leeway in designing policies to which plans must adhere, and this is particularly significant for immigrant populations. Issues which demand especially close scrutiny include: 1) length of enrollment periods (how long someone participating in mandatory Medicaid managed care is given to select a plan before s/he is assigned to one, known as auto-assignment); 2) lock-in time periods in a given plan (how long someone must remain in a plan once s/he has enrolled); and 3)the widespread availability of marketing and other plan materials in the plan holder's language.

A 1996 study by the Community Service Society of New York demonstrates that Medicaid beneficiaries do not understand the basic concepts of managed care and are therefore less able to effectively utilize, and benefit from, its services. CSS surveyed 421 Medicaid recipients (both English and Spanish-speaking), 68 percent of whom were either currently enrolled in a managed care plan or had once been enrolled. The study found that significant numbers of respondents were not told about limited provider networks, were not told how to acquire specialty care, were not told about restrictions on emergency room use, and were not given provider lists. Respondents who identified their primary language as Spanish were less likely to have enrolled in a managed care plan than English speakers.[11] (Community Service Society of New York, *Knowledge Gap: What Medicaid Beneficiaries Understand-and What They Don't-about Managed Care*. December 1996). These findings clearly point to the need for aggressive public education campaigns about the workings of managed care for all potential and current enrollees. Outreach of this kind is especially important for limited English speakers. The CSS study demonstrates that inadequate language services (or at least the perception of inadequate services) on the part of managed care plans may be preventing large numbers of limited English speakers from enrolling in managed care, or may be responsible for disenrollment.

Language-appropriate services must be available at all points of managed care service delivery. Adequate signage services in a range of languages should be present. All materials need to be translated into the languages of the plan's clients, and sufficient numbers of trained interpreters need to be available. The need for medical interpreters goes beyond the

examining room. Managed care plans need to provide comprehensive language services for intake and billing discussions, telephone contacts with clients, health education seminars, in the customer service/complaint departments, and, of course, in the examining room. Health care providers and staff should be trained on working with interpreters and on the cross-cultural medical interview.

Efforts to make managed care mandatory for Medicaid enrollees are in effect in numerous states across the country. While studies demonstrating a gross lack of understanding about managed care among this population raises cause for concern, the drafting of new legislation does provide states with a ripe opportunity to incorporate linguistic access requirements into their managed care contracts. As partners with the federal government in funding Medicaid, states have an interest in ensuring that patients receive the quality care for which they are paying, and that managed care providers act in accordance with state and federal civil rights laws.

This opportunity has compelled a number of states--notably California, Massachusetts, Illinois, and Washington--to write explicit language access provisions into their managed care contracts. When California underwent a transition from Medi-Cal (the state version of Medicaid) to managed care, advocates for immigrants, led by the National Health Law Program, issued a series of recommendations designed for incorporation into state managed care contract guidelines. This report urged that language services be available according to the numbers of patients in one language group in a given zip code. When the number of patients did not meet a service area threshold, telephone interpretation was urged, at minimum.[12] The California legislature subsequently incorporated the report's provisions into its requirements for managed care plans seeking to contract with the state for Medicaid enrollees. There are specific requirements for both medical and non-medical interactions and services detailed in the addendum to the state's Request for Applications. Language needs assessments of managed care plans' patient populations were also required from the applicants. To ensure implementation of comprehensive language provisions, contractors were required to submit a Cultural and Linguistic Services Plan within six months of the beginning of year two of operations. The development of mechanisms to ensure continuity in the assignment of interpreters when follow-up care was needed were also mandated.

Like many states, New York is shifting its patients to Medicaid managed care in an effort to hold down health care costs. Currently, mandatory managed care is only in effect as part of a demonstration project in southwest Brooklyn. The New York State Department of Health has sought a waiver from the federal government to enroll nearly all of the State's 3 million Medicaid beneficiaries into managed care plans. Though necessary consumer protections have been enacted over the past year, in the form of a Managed Care Bill of Rights and regulations on grievance procedures, provider protections, network capacity, and the right to a fair hearing if claims are denied, numerous other safeguards are lacking. This is particularly true in the area of linguistically appropriate services, materials, and the

screening, training,and availability of interpreters.

The current contract that exists between the New York City Mayor's Office of Medicaid Managed Care and managed care plans serving Medicaid enrollees, which is in effect until April 1998, only requires the translation of plan materials and the provision of interpreter services when a given language is spoken by 10% or more of a borough, subject to a minimum of 500. This leaves many individuals who do not meet this threshold vulnerable to misleading marketing tactics, and does not bode well for them once they are enrolled. Following a 30-day period in which members can disenroll from a plan, they are locked in for 6 months. In the absence of language services, and any specific requirements regarding a plan's bilingual provider capacity, significant portions of a plan's membership are afforded no protection that their heath care needs will be adequately met. But with contracts up for renegotiation in numerous localities, a window of opportunity exists for advocates to demand system-wide uniformity of linguistic access and for managed care providers to understand the linguistic and cultural dimensions of their members.

III. National Model Analysis Findings

To explore the range of approaches to the delivery of medical interpreter services that exist around the country, and to evaluate the feasibility of replicating these in New York City, the Task Force conducted a nationwide analysis of a number of existing interpreter services initiatives.

The structures of interpreter programs vary according to the specific needs of local populations, the numbers and types of languages spoken, and the structure of health care facilities and health care service delivery in a given area.

In the ATMILS National Model Analysis, the following aspects of interpreter programs were assessed:

- Historical, ethical, legal, and demographic factors that influenced program implementation
- Demand for, and supply of, services, including the number of patients served, and the variety of languages offered
- Program operations and systems
- Interpreter training: methodology, scope, standards, and costs
- Standards of practice and certification
- Institutional protocols for caring for non-English speaking patients and guidelines for utilization of interpreter services

The following is an overview of the major ATMILS findings including: a) the catalysts for the development of interpreter services, b) their organization and program operations, c) processes for the screening and training of interpreters, and d) the role of data collection and evaluation.

Motivations in the Development of Medical Interpreter Programs

The motivation to develop an interpreter program was frequently shaped by one or more of the following:

- *Pressure from physicians.* At many of the facilities surveyed, providers had been increasingly voicing their frustration to hospital administrators about being unable to effectively communicate with their patients. They felt that the quality of the care they delivered was being significantly compromised by the absence of trained interpreters.

- *Desire to gain a larger share of the market through increased patient volume.* The availability of interpreter services acted as a major selling point to the specific patient populations served. Even with small improvements in the provision of linguistic services, volumes of paying and insured patients surged. This provided a strong argument for the development of formal programs.

- *Threat of malpractice law suits/Need to comply with federal mandates (Title VI of the Civil Rights Act of 1964).* In Seattle, for example, little progress was made in meeting the linguistic needs of newly arrived immigrant and refugee populations until 1981, when Evergreen Legal Services lodged discrimination complaints with the regional HHS Office for Civil Rights on behalf of three clients at three separate Seattle hospitals. In order to avoid lawsuits, hospitals developed interpreter programs to ensure that non-English speaking patients received adequate care.

- *Necessary response to the influx of refugee/immigrant patients and a desire to fulfill facility's mission statement.* In Minneapolis, the documentation of the huge influx of new refugees into the city in the early eighties was enough impetus to get the hospitals' administrations to develop their own interpreter services. In addition, many of the interpreter programs surveyed noted that their mission statements included a commitment to serving poor, often neglected populations.

- *Providing in-person interpreter services is more cost-effective than telephonic interpreter services.* According to a report by the National Public Health and Hospital Institute, the average cost of a face-to-face interpreter interaction was $20.04. At one hospital in Los Angeles, the average cost was $12; in Boston, $14. This sharply contrasts with the fees for the use of the AT&T Language Line, a service which institutions can subscribe to for access to an interpreter on a 24-hour basis. AT&T fees range from $2.20-$4.50/minute, depending on time of day and language. A 20-minute interview using the AT&T Language Line would, therefore, cost between $44 and $100.

Organizational Structure of Medical Interpreter Programs

There is a broad range of approaches used by facilities to meet the language needs of their multilingual patient populations. Common components include:

- *Hiring bilingual providers.* This is universally the preferred approach, both for its cost effectiveness and for its effect on the provider-patient relationship. Unfortunately, there is a dearth of foreign-born providers, and these providers, when available, are frequently called upon to interpret for other providers, creating a backlog of patients. In addition, because immigration trends are not static, it is

difficult for provider hiring policies to keep pace with new immigrant populations, making this a difficult strategy on which to depend.

- *Staff interpreters.* These employees are either full or part-time, depending on the level of commitment from the administration, as well as the language needs. Full-time interpreters are on payroll and receive benefits. In several facilities, the employees were hired as clerical workers because the job title "interpreter" is only slowly starting to be recognized.

- *Part-time freelance interpreters* who generally interpret for infrequently encountered languages and after-hours. They are paid on an hourly basis and, in some cases, may receive partial benefits.

- *A regionally-based interpreter pool.* In some geographic areas where many facilities needed interpreter services, health care facilities chose to combine their resources and create a centralized pool of available trained interpreters. According to one interpreter services director, when numerous facilities invested in the interpreter pool, the program was less vulnerable to budgetary fluctuations.

- *Contract with a community-based organization (C.B.O.) for interpreter services.* This was the model in two demonstration projects. The C.B.O. hires, screens, and trains the interpreters, coordinates the dispatching, and is paid a lump sum for service by the health care facility.

- *Reliance on a hospital language bank and/or volunteer program.* Many facilities use volunteers to do interpretation, especially for less common languages, or as a back-up strategy when staff interpreters are not available.

The Use of Bilingual Staff as Interpreters

In the absence of trained designated medical interpreters, bilingual staff members are often used for interpretation. All facilities surveyed recognized the importance of bilingualism/biculturalism in hiring. These individuals are commonly viewed as an adequate solution to communication barriers. Facilities keep a list of bilingual staff ("a language bank"), their department, and their schedule, and consult the list when an interpreter is needed.

There are, however, a number of problems with this approach. Typically, language proficiency is determined by self-report, so there is minimal quality control. Staff who claim to be bilingual are rarely, if ever, screened for their level of proficiency or their knowledge of medical terminology. They may be pulled away from their regularly assigned duties for a number of hours at a time to interpret, while still being expected to carry the same workload as their monolingual counterparts. In some cases, hospital clerical workers' unions have

pointed to the undue burden this places on these staff members, and have instructed staff not to interpret or, if they do, to demand a pay differential. The era of cost-cutting in health care has created an additional problem with this approach. Because the recognition of the importance of hiring bilingual staff is a relatively new trend, and because layoffs are typically based on seniority, bilingual staff are generally the first to be dismissed. This creates shortages in the available pool of bilingual staff, and further constrains those staff who are still relied upon for interpretation.

Recognizing the constraints under which bilingual staff operate, various policies on the use of bilingual staff for interpretation have emerged. At one facility, bilingual staff members who interpret for a minimum of 10 hours biweekly qualify to receive a pay differential. The director of interpreter services at this facility did not recommend this as a strategy. Staff were no more willing to interpret and they tended to pad their hours. Additionally, full-time staff interpreters were far better trained than were the untrained bilingual staff who were asked to serve in this capacity.

Another general category of policies concerning the use of bilingual staff for interpretation is that which attempts to restrict their regular, unqualified use. At one facility, bilingual staff who interpret are not permitted to do so away from their workstations due to staffing cutbacks. At a number of facilities with established interpreter programs, the supervisor's permission must be obtained before a staff member can be called upon to interpret.

One California facility has a policy that bilingual staff can only interpret in 15 minute segments. After that time, an interpreter must be called. This largely restricts these staff members' interpreter encounters to non-clinical interactions. This approach not only minimizes the time that staff are pulled away from their jobs, but also reinforces the notion that when facilities rely upon untrained interpreters, particularly for clinical encounters, they are assuming a great liability.

The Use of Volunteers as Interpreters

There is a broad range of perspectives on the appropriateness of relying upon volunteers for interpretation. Their commitment may be short-term and they may be placed in situations where there should be considerable training and on-the-job experience. Some facilities prohibit volunteers from interpreting altogether, while others require volunteers who interpret to commit to a minimum number of hours per week. Many facilities surveyed thought the use of volunteers was sometimes unavoidable, especially after-hours. A number of institutions place restrictions on the use of volunteers, such as allowing them to serve as interpreters only in non-clinical capacities (i.e. intake, admissions, and scheduling). To distinguish them from trained designated interpreters, volunteers are identified as language liaisons. None of the sites visited, however, relied exclusively on volunteers for interpreting.

Commercial Telephone Interpreter Services

In recent years, there has been a growth in the availability of commercial telephone interpreter services. The AT&T Language Line is a 24-hour telephone interpreter service that allows doctors and patients who do not speak the same language to communicate for a monthly subscriber fee and a per call rate to the hospital. Pacific Bell has a similar service. Both are expensive, with a per-minute rate of between $2.20 and $4.50, depending on the time of day and the language. At health care facilities which do not have established interpreter programs, use of the line tends to be considerable. Many of the facilities with established interpreter programs at one time spent large sums of money on telephone interpretation but then calculated that it was far more cost effective to hire a combination of full and part-time interpreters. Their continued use of telephone interpretation is generally only in case of emergency or when there is a particularly rare language. Many facilities surveyed were concerned that interpreters who work for the service are not trained in medical terminology, though Pacific Bell has a medical consultant on hand.

Access to language lines is often limited. For example, there may only be utilization for emergency room providers; requests for the service may have to go through the interpreter department, which would authorize its use when an interpreter cannot be located; or requests may have to be cleared by a departmental supervisor.

The Use of Family, Friends, and Bystanders as Interpreters

Problems associated with the frequent use of family members and clinic bystanders was a significant impetus for the development of interpreter programs. Such ad-hoc strategies have a number of serious ethical, legal, and medical implications. Hospital administrators recognized the extent to which they could be held liable in the event of a complication. Most interpreter service directors acknowledge that the use of such ad-hoc interpreters is probably still far more common than they are aware. This underscores the importance of conducting provider training on the problems related to the use of untrained interpreters, who cannot be impartial, may not be bilingual (especially with regard to medical vocabulary), and whose use violates doctor-patient confidentiality.

Policies on the Use of Ad-Hoc Interpreters

There are varying policies regarding the use of non-hospital personnel for interpretation. While some facilities have outright prohibitions on the use of these individuals as interpreters, others may only discourage their use. Some facilities may only ban the use of children as interpreters. Many of the facilities surveyed reported the situations when patients insisted upon the use of a family member to interpret. In light of the potential problems that

arise from relying upon these individuals, one facility requires these patients to sign a waiver that ensures they understand the pitfalls of using untrained interpreters.

Program Operations and Systems

At the facilities surveyed, interpreter services programs were located in a variety of divisions, including Social Services, Community Relations, Ambulatory Care Services, Patient Relations, and Volunteer Services. Of even greater significance than the location of interpreter departments within the organizational structure was their level of administrative support. Also essential to the continued success of interpreter programs was the ongoing collection and presentation of data on the demand and cost-effectiveness of interpreter services. This is an essential aspect of attaining administrative support.

Coordination and Dispatching of Interpreters

Interpreter services surveyed generally had one of two approaches to requests for, and scheduling of interpreters: a 24-hour dispatcher/on-call scheduler or a multilingual service with appointment call-backs. There are advantages and disadvantages to both systems. The voice mail system minimizes the staffing required. However, some facilities report with this system that there are a substantial number of hang-ups, which is likely due to callers' unfamiliarity or frustration with such systems.

The most administratively advanced interpreter programs operate have a computer system for both pre-scheduled appointments and walk-ins. Interpreters receive a computer printout of all of their pre-arranged appointments for the day, which are then supplemented with walk-in cases (via beeper or overhead page) and other on-demand services. Some hospitals have in their registration databases a field which asks the patient's primary language and whether s/he needs an interpreter. Other scheduling approaches at surveyed sites include:

- Requests for interpreters are taken via fax, e-mail, and phone; prioritization of interpreter requests coordinated by a central dispatcher, who screens requests to determine the nature of the appointment. In one example, all Emergency Room requests are placed at the top of the list.
- A policy that only providers can phone in interpreter requests;
- A system in which interpreters call the interpreter office regularly to check for new interpreter requests.
- As an alternative to pre-scheduling, one Massachusetts hospital designated interpreters to be stationed in high volume departments.
- Reminder phone calls and postcards to decrease the patient no-show rate.

Taking Interpreters Seriously: The Position of Interpreters in the Hospital Hierarchy

As members of a relatively new field, medical interpreters are struggling to define themselves in the organizational structure of health care facilities. Much of the difficulty comes from a lack of understanding among administrators and providers about the role and the importance of the interpreter. Established interpreter departments have addressed these issues in a number of ways. One of the most basic, yet effective, was to create the job title "interpreter," which is clearly displayed on their ID badge. In some health care facilities full-time trained interpreters have liability coverage which helps to substantiate interpreters' professionalism.

Utilization of Interpreters

In spite of the overwhelming need for trained medical interpreters, at some institutions they have been underutilized. There are two primary reasons for this: 1) providers and patients overestimate their own bilingualism, and 2) both providers and patients are unaware that trained medical interpreters are available. Public education and provider training on the importance of using interpreters are essential.

Overestimation of Language Ability

Often, in the interest of saving time, providers will attempt to conduct a medical interview in a language in which they are not fully proficient, despite of the existence of trained interpreters.

Patients are also prone to overestimate their bilingual proficiency or are too shy to request an interpreter. Language needs assessments are often done in an ad-hoc manner at the patient's first point of service (usually an intake desk). While many limited-English proficient persons can understand basic questions such as, their name, address, and date of birth, they are often not well versed in medical vocabulary, and consequently, their language needs are not identified until well into the medical interview.

Lack of Awareness about Interpreter Services

Providers' and patients' lack of awareness about the existence of interpreter services also leads to their under-utilization. A number of established interpreter programs have recently begun publicizing interpreter services during staff orientation and in residency training programs. Reminders about the service appear in hospital newsletters, as well as throughout the facilities. At some hospitals, signs and stickers alert patients to the availability of interpreters. Inpatients may receive interpreter information in patient orientation packages. One facility initiated interpreter "rounds," in which interpreters leave their

business cards at patients' bedsides. In Chicago, after a state interpreter services law was enacted in 1993, a community-based organization began an extensive public education campaign. It distributed informational cards that non-English speaking patients could present to providers informing them of their need for, and right to, an interpreter.

The Role of the Interpreter

There exists a broad range of opinions on what exactly should be the role of medical interpreters. Some argue that medical interpreters should act as culture brokers, if necessary. In many interpreted encounters, there is not just a language barrier, but a cultural one as well. An interpretation which fails to offer a cultural context may not give the provider the tools necessary to make a sound judgment or medical diagnosis. Subtle cultural clues that may only be detected by interpreters may make a considerable difference in how patients' health--both physical and mental--is understood. It is for this reason that many established interpreter programs attempt to match patients repeatedly with the same interpreter with whom they can establish open communication. In this context, the interpreter acts as a liaison between the patient and the provider and can intervene in the case of cultural misunderstandings.

On the other hand, others insist that interpreters should resemble "bodiless voices," interpreting exactly what is said without any additions or omissions. This approach is based on the belief that interpreters do not have the appropriate training to make subjective judgments in the context of medical encounters. When they act in this capacity, the provider-patient relationship is fundamentally altered. The same person can function as a culture broker and an interpreter, but a person cannot be both at the same time.

Interpreter Screening and Training

Screening

Because medical interpreting is a skill requiring more than bilingualism, careful screening of candidates is essential. Bilingualism is only the minimum requirement. Medical interpreters must have strong interpersonal skills, a good understanding of the dynamics of the provider-patient relationship, awareness of one's own cultural beliefs, and adherence to an interpreter's code of ethics, which includes the patient's right to confidentiality. Typical screening tests are oral and written and contain role-play vignettes. For prospective interpreters of rare languages, screening standards and strategies may have to be altered. Interpreter services directors use a selection of the following screening strategies:

- Recruitment of candidates whose first language is not English, and evaluation of their bilingualism by having a conversation in English.
- Asking ethnic community leaders to evaluate the candidate's language proficiency.

- Contracting with an outside language company to evaluate candidates who might serve as interpreters, particularly for rare languages. Oftentimes, however, these agencies' services are not limited to medical interpretation, so they may not have specific medical assessment tools.
- The use of tests which evaluate candidates' written ability in English and in their other language. These tests generally look for the individual's level of vocabulary, and may also ask that they do a site translation.
- Audiotaped tests.

Training

There are a range of approaches to training medical interpreters. Interpreter training programs often combine many of the following elements:

- Didactic training conducted by an experienced interpreter.
- An initial test and trial period in which the candidate shadows an experienced interpreter. This approach works only with an established interpreter department. Training the first pool of interpreters is crucial to assure the quality of future interpreters.
- Role plays, videotaped for critique.
- Memorization and focusing exercises.
- Ongoing development of medical glossaries.
- Ongoing review of medical procedures and terms.
- Exploration of the context and culture of the medical institution and medical interview.
- The development of awareness about the interpreter's own cultural beliefs and biases.
- Review and adoption of an interpreter's code of ethics.
- Discussion of: patterns of immigration and intra-linguistic and intra-cultural group differences; differences in health beliefs and practices across cultures.
- Training modules on difficult situations that may arise in medical encounters, e.g. crisis intervention, doctor-patient power differentials, and death/dying.

Because medical interpretation is a relatively new field, the identification of an appropriate trainer has been a difficult process for a number of interpreter programs. Only just recently have standards and guidelines started to emerge. The ideal trainer has personally experienced interpreting in a health care setting and has a solid grasp of the techniques needed for effective interpreting. In addition, the trainer should be an effective teacher, with the ability to engage the class. Because the deaf/ASL community has had much more extensive experience with interpreting, it has been suggested by some that trainers can be successfully recruited from that field.

Emerging Trends in Medical Interpretation

The Development of Standards of Practice

Given the relatively recent introduction of professional medical interpreters into health care settings, it is not surprising that there has not yet emerged a set of industry-wide standards that dictate the requirements for the profession, nor any guidelines to assist interpreters in what can frequently be very difficult scenarios. Indeed, there is a vast range of opinion in the interpreter community about what might constitute "Standards of Practice." There is debate about standards of excellence vs. pragmatism. For many health care facilities, it is unrealistic to think that medical interpretation of equal accuracy, completeness, and efficiency can exist regardless of the language. In many communities, there is a limited number of sufficiently bilingual individuals, a fact which makes it difficult to insist on a set of standards which may eliminate the best resources, given the circumstances. Nevertheless, efforts to design a protocol for medical interpreters have grown in recent years.

The creation of standards is seen by many as a necessary step in the eventual professionalization of medical interpreters. According to interpreter services directors, there is a need to define in writing what distinguishes medical interpreters from lay interpreters, such as bilingual staff. If these two positions are formally distinguished from one another, there is a greater likelihood that medical interpreters will be viewed as skilled professionals, and their importance will be more widely recognized. Standards provide a baseline of expectations for consumers, interpreters, and providers. The development of standards of practice is also important to facilitate the creation of interpreter programs where they do not currently exist. The Massachusetts Medical Interpreters Association (MMIA) handbook has made great strides in the creation of professional guidelines for medical interpreters.

Certification

As interpretation has become more widely available in recent years, discussion has increasingly turned to the need for interpreter certification. Without standards, though, certification becomes difficult. National collaboration at interpreting conferences would be an ideal forum for developing and implementing standards and certification procedures.

Trends in the Financing of Interpreter Services

- *Hospital-financed programs.* While, in many cases, interpreter services departments were initially funded through grants and auxiliary funds, most hospital administrations eventually developed budget lines for their programs. Once hospitals were convinced of the need for interpreter and language services, interpreter departments tended to be exempt from budgetary cuts, though expansion of staff and funding increases were relatively uncommon. When they did occur, they had to be justified

by data demonstrating increased demand for services and the cost-effectiveness of expansion.

- *Medicaid reimbursement.* While written into the law, Medicaid reimbursement is rarely utilized. State policies on this issue vary tremendously. In 1993, Washington became the only state to create a mandatory separate billing code for interpreter services.

- *Managed care organization cost-absorption.* As managed care becomes the dominant health care delivery system (for both Medicaid and non-Medicaid recipients), the value to these organizations of providing linguistic services, even at their own expense, is likely to become increasingly apparent. Metropolitan Health Plan, an HMO based in Minneapolis, coordinates and finances interpreters for hospitals serving its clients. They found that this significantly increased their enrollment. A number of individual states, as they prepare to award managed care contracts to HMOs, are making linguistic services provisions a condition for receiving contracts.

Data Collection and Evaluation

Interpreter services providers, many of whom are continually faced with having to justify their existence to fiscally-minded administrators, repeatedly spoke of the need to record the demand for services and to frequently evaluate efficiency. Need documented by language requested, by department, by time-of-day, and in-patient vs. outpatient underscores the importance of continued program development, training for staff and volunteers, and, in the ideal case, the hiring of full-time staff interpreters. Evaluations of cost, efficiency, and improved satisfaction and outcomes need to be systematically done. To date, data has been used for in-house purposes only. National dissemination of such studies would be an impetus for the widespread development of a professional class of medical interpreters.

Conclusion

Language continues to act as a major barrier to health care access for non-English speaking immigrants. It will become more of an issue as the number of immigrants residing in the United States continues to grow. As the site visits illustrate, a number of heath care institutions have made innovative strides in removing this barrier. Established programs can serve as valuable models and provide a base upon which others can build. The programs outlined above demonstrate that interpreter services can improve health outcomes, be cost-effective, and help health care organization increase patient volume, even during an era of cost containment and increased market competition. The programs also demonstrate the importance of training providers and interpreters, and of developing a broad base of support to aid the successful implementation of such a program.

IV: New York City Interpreter Needs Assessment Findings:

Background

The model analysis of existing interpreter programs provided the Task Force with a wealth of information on the essential aspects of medical interpreter services. This data is being used in the work of ATMILS, designed as an alternative to the prior piecemeal approach to the provision of linguistic services in New York City's health care facilities. ATMILS will act as a centralized source of information and ongoing instruction, and as a forum for continuous dialogue among medical interpreters, service providers, community-based organizations, and immigrant communities. The Task Force's linguistic services recommendations are a product of the ATMILS national model analysis and of the language needs assessments of New York City health care facilities, a summary of which follows. A list of the facilities surveyed can be found in the Appendix.

This summary is presented as follows:

- Linguistic service needs of patients.
- Current strategies used to address language needs of patients.
- Organization of interpreter services within hospital structure.
- Methods of screening and training interpreters.
- Methods of financing existing interpreter services.

Linguistic Service Needs of Patients

To design an interpreter program specific to New York City's needs , one must determine what languages are spoken, at what facilities and units, by how many people, and at what times. In New York, most of this information is anecdotal. There is little systematic record-keeping.

Current Strategies Employed

The lack of a systematic approach to medical interpretation in New York City has forced hospitals to address the need for linguistically appropriate services through a patch-work of strategies. Bilingual staff, volunteers, family members, and outside agencies are used to address language gaps.

- *Language bank development.* Language banks are among the most common re-sponses to the need for interpreter services. The se are, generally, are an informal

registry of staff who have agreed to act as interpreters. With a few exceptions, the interpreters undergo little, if any, screening or training. Language bank participants are bilingual only according to self-assessment. Contact persons at New York facilities uniformly reported that their language banks suffered from a lack of coordination. In addition, hospital unions have complained about the unfair burden these place on bilingual workers.

In general, the department that compiles the language bank registry acts as its coordinator. The most common way to get a language bank interpreter is for a clinician to request one from the coordinator or the page operator. This system suffers from inefficiency because, for out-patient facilities, requests are made only once the patient is at the facility, so there is usually a considerable wait until the interpreter arrives.

- *Use of the AT&T Language Line.* Many New York facilities rely heavily on the Language Line. One New York hospital spends more than $10,000 per month on the service and installed speaker phones in every exam room to accommodate it.

- *Use of family, friends, and bystanders as ad-hoc interpreters.* Reliance on untrained hospital staff as interpreters, as well as friends, family, and anyone else who might be bilingual, is extremely common. Ad-hoc interpreters are neither screened for bilingualism nor trained in medical interpretation techniques, the interpreter's code of ethics, nor the role and responsibilities of the interpreter. In many cases they may breach confidentiality. Family members are not objective and their use may interfere with family dynamics. Untrained interpreters frequently add, omit, condense, and substitute words or phrases. In most cases, the New York facilities recognized the problems associated with untrained interpreters but felt that their use was unavoidable, given the lack of dedicated interpreter staff.

- *Use of trained interpreter services, when available.* The widespread lack of interpreter services at New York health care facilities led to the initiation of a for-credit college course on medical interpreting, taught at the City University of New York's Hunter College. The Community Interpreter Project (CIP) has trained bilingual students to interpret in Haitian Creole, Russian, Spanish, Mandarin and Cantonese. The demand for CIP students is far greater than what can be provided. Because it is an academic program, there is a high turnover rate. Still, hospitals which have used CIP interpreters have expressed high satisfaction with their performance.

  In addition to CIP, there have been two other efforts in New York to address the linguistic needs of non-English speaking patients through the use of trained volunteer interpreters: one sponsored by the Health and Hospitals Corporation at Bellevue Hospital, the other at Columbia-Presbyterian Hospital. The screening and training

modules used by both facilities are intensive. Providers acknowledge the value of having trained interpreters when they are finally in the presence of one. Still, these facilities face a severe shortage of interpreters.

In each of these three programs, there remain significant scheduling problems. There is a need for improved systems management and provider education about making use of and working with interpreters.

Organization of Interpreter Services

In the absence of budget lines for interpreter services, the services which do exist are often provided by volunteers. Other departments most directly linked to the provision of interpreter services are Social Work, Corporate Community Development, and Patient Relations. In general, language services in New York City facilities suffer from a lack of centralized coordination, primarily because no one department has the resources to shoulder the entire responsibility (organizational and financial) for such a large need.

Screening and Training

Interpreter programs in New York are fairly underdeveloped relative to those in many other major urban areas. There are few training modules in place, and even fewer assessment tools to screen for bilingualism. Interpreters self-assess their skills. The level of interest among staff used as ad-hoc interpreters in being trained varies a great deal.

Columbia Presbyterian Hospital's Volunteer Interpreter Corps receives a 20 hour training course over a two week period. Beth Israel Medical Center sponsored a training seminar for some of its volunteer interpreters, taught by an outside agency from California. Bellevue Hospital Center also sponsors a training course in simultaneous interpretation for bilingual student volunteers, staff, and volunteers. In addition to these hospital-based programs, the New York Task Force on Immigrant Health offers a 48-hour training course for bilingual health care staff and volunteers who are frequently asked to interpret. Most other facilities with less established interpreter programs "train" merely by offering interpreters lists of commonly used medical vocabulary. Some administrators expressed a reluctance to invest in training for volunteer interpreters because of their high turnover rate. The two most common complaints about ad-hoc interpreters are that they have poor English skills and that they get too personally involved. These are both directly tied to a lack of screening and training.

Financing of Existing Services and Administrative Support for Interpreter Programs

The lack of allocated funds for interpreter programs is by far the greatest roadblock to their development. The most difficult step appears to be obtaining the initial start-up money and support from hospital administrators. As one volunteer coordinator put it, public hospitals, in particular, are just not in a position to do anything that is not directly revenue-producing. Once even the most bare-bones services are put in place, practitioners realize the tremendous difference in using trained professional medical interpreters and become powerful advocates for their institutionalization.

Currently, at most New York City facilities, whatever money is spent on interpreter services generally comes out of the hospital's auxiliary fund, with the exception of Columbia-Presbyterian, whose program is both grant and administration-supported. At the time the Task Force conducted its site visits, facilities did not have specific budget lines for interpreter services, and no facilities had provided interpretation services from an enhanced Medicaid rate. All of the facilities, however, voiced an interest in the development of creative strategies to fund interpreter services.

Summary of Findings and Implications

Interviews with persons involved in the ad-hoc provision of interpreter services, as well as discussions with administrators and volunteer coordinators, demonstrated that medical interpretation is increasingly perceived as an essential service, and that there is a general awareness that the current provisional arrangements will not suffice.

The level of interest expressed by all of those currently trying to meet the linguistic needs of their patient populations suggests that a model based on a combination of on-site and shared resources is feasible and deliverable for New York City.

V: Recommendations for the Implementation of Interpreter Services in New York City

General Recommendations

A flexible approach to the development of interpreter services should be developed, taking into account the particular needs and circumstances of the individual facilities. The overall program design for New York should build upon current resources, including the existing pool of both bilingual volunteers and staff. The model should promote the reconfiguration of job descriptions for bilingual staff, many of whom currently interpret on an ad-hoc basis and experience considerable role conflict. Ultimately, New York's program should utilize the services of both on-site and on-call trained staff and freelance interpreters, whose jobs are almost wholly focused on linguistic access. A Task Force-based coordinating structure should be established to provide continual technical assistance for both program implementation and evaluation. This will ensure optimal shared resources and economy of scale, and will enable the use of emerging technologically-enhanced interpretation systems.

Detailed needs assessments should be done by all facilities. Patients should be asked their primary languages and about their interpreter needs. Results should be computerized when possible. This information should be updated on a regular basis. Facility needs should be continuously evaluated according to languages served and location within the health care facility.

Specific Program Recommendations

Volunteer-Based Program Recommendations

- Name a coordinator for interpreter services at each site.
- Recruit volunteers to act specifically as interpreters.
- Screen volunteers for language proficiency.
- Train the volunteer interpreter workforce.
- Require a minimum weekly and total commitment from all volunteer interpreters.
- Conduct monthly debriefing and continuing education sessions.
- Record the total number of hours and sites served by volunteers.
- Provide volunteer recognition.

Bilingual Employee Language Bank Program Recommendations

- Screen bilingual employees for language ability and commitment to serving as interpreters.

- Conduct a modified training.
- Use only when volunteer or staff interpreters are unavailable.
- Limit utilization to basic interpretation.

The Task Force also recommends the redistribution of bilingual hospital personnel who are willing and able to serve as interpreters, following the completion of a training course. Their job descriptions should be reconfigured to include interpretation tasks.

The Task Force is in the process of negotiating a strategy, in conjunction with the Community Interpreter Project (CIP), to train and place student volunteer interpreters throughout New York City. CIP is currently offered to Hunter College students. However, it is seeking to expand to other City University of New York (CUNY) campuses. A coordinated effort would greatly expand the presence of medical interpreters in New York City, make efficient use of a valuable source of bilingual people, and would further current attempts to standardize practice, through the integration of curricular and training initiatives.

Trained Full-time and Part-time Staff and Pool Interpreters:

These will ultimately be the cornerstone of interpreter services. The Task Force will sponsor efforts to develop creative training and implementation strategies. Among the structures the Task Force will recommend are the following:

- Full-time staff interpreters for the two or three most commonly encountered languages at each facility.
- Part-time/on-call interpreters for other frequently encountered languages.
- In the case of rare languages, facilities should have a clear, hospital-wide procedure.
- Consider a computerized dispatch and scheduling system. At outpatient sites, interpreter visits should, when possible, be scheduled at the time a patient's visit is scheduled. For "walk-in interpretations," implement a beeper system.
- Participate in and assist in maintaining a borough-wide pool of trained interpreters who are available on a per-hour basis. This model would be effective in addressing the constraints created by the large number of languages in New York City, and the inability of each facility to hire interpreters for every language it encounters. Facilities could individually negotiate rates with interpreters, but would be required to pay them within a fixed range.
- Encourage facilities to consider innovative technologically-enhanced approaches to interpretation, including pooled services.

Institutionalization of the ATMILS Interpreter Training Program

The training of ATMILS interpreters will follow a two-tier structure, in which community members unfamiliar with medical terminology and medical settings will be given supplemental training sessions in addition to those provided for bilingual medical personnel. Additional education about immigrant entitlements in New York, particularly in relation to the new Federal welfare reform law, the New York State Child Health Plus insurance program, and recent changes in Medicaid/managed care will be included. Didactics, role plays, videotape review, and peer and self critiques will be used. These trainings will be offered at the Task Force and on-site at the health care facilities.

Recommendations for Training of Providers on Working with Interpreters

The education of providers on how to work with interpreters is central to the delivery of culturally and linguistically appropriate health care. These trainings teach providers skills to facilitate cross-cultural medical interviews, and discuss the differing roles and responsibilities of providers and interpreters, as well as the dangers of using untrained interpreters and of relying on one's own self-assessed linguistic abilities. The NYTFIH will offer these provider trainings. They will be based on the successful trainings the Task Force has already implemented in the area of cross-cultural health care and working with interpreters.

Partnerships with the Community

The Task Force will facilitate bridges between the health care facilities and community-based organizations, with which it already has established relationships. These agencies represent an important resource for the widespread dissemination of interpreter services. The interpreter services program will provide an important job development opportunity for New York's immigrant communities. The community will have extensive input through both the Advisory Board and supplementary meetings. The Advisory Board will closely monitor blueprint implementation.

Community Education Campaign

The language access program will also seek to raise awareness among immigrant communities about their right to receive linguistically appropriate health care services.

Standards of Practice

The Task Force will, in partnership with the national medical interpreters' movement, continue to promote the development of, and interest in, standards of practice. Additionally, the Task Force will advance program development for interpreter certification. While the practice of certification raises a number of complex issues, given the range of cultural perspectives that interpreting encompasses, it remains a necessary objective. It is quite likely that upon the implementation of high standards of practice and comprehensive training programs, medical interpreting will increasingly be seen as an essential component of the cross-cultural health care encounter. In turn, those who perform this service will be recognized and compensated appropriately. Quality assurance and monitoring tools based on standards of practice will be developed and utilized.

Data Collection, Evaluation, and Next Steps

New York is at a critical turning point in the development of medical interpreter services. The development of and interest in training programs and professional standards of practice is evidence of a growing sentiment that the patchwork of strategies commonly used to address the needs of limited-English speaking patients is not perceived as an adequate long-term solution. To document to health care facility administrators and policy makers the need for trained, professional medical interpreters, data must be collected and evaluated. Data analysis should address patient and provider satisfaction, quality, cost effectiveness, need, demand, and adherence.

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Appendices

A. Interpreter Programs Visited in Model Analysis

California: Asian Health Services (Oakland); San Francisco General (San Francisco); Stanford University Hospital (Stanford); Sharp International Health Services (San Diego); University of California at San Francisco Medical Center (San Francisco); San Francisco Kaiser Permanente (San Francisco); San Francisco General Hospital (San Francisco); Cedars-Sinai Medical Center (Los Angeles); **Florida:** Jackson Memorial Hospital (Miami); **Illinois:** Cook County Hospital (Chicago); Mount Sinai Hospital (Chicago); Immigrant and Refugee Task Force/Heartland Alliance (Chicago); **Massachusetts:** Beth Israel Hospital (Boston); Boston City Hospital (Boston); Boston Children's Hospital (Boston); University of Massachusetts Medical Center (Worcester); **Minnesota:** Community University Health Care Center (Minneapolis); Hennepin County Medical Center (Minneapolis); St. Paul-Ramsey Medical Center (St. Paul); University of Minnesota Community Interpreter Training (Minneapolis)

B. Health Care Facilities Visited in New York City

- Bellevue Hospital Center
- Beth Israel Medical Center
- Bronx-Lebanon Hospital
- Coney Island Hospital
- Elmhurst Hospital Center
- Gouverneur Diagnostic and Treatment Center
- Lutheran Medical Center
- New York Downtown Hospital
- The Bronx Health Plan
- Columbia Presbyterian Hospital

C. Additional Resources for Medical Interpretation

The Cross Cultural Health Care Program
1200 12 Ave. S
Seattle, WA 98144
(206)621-4161

Massachusetts Medical Interpreters Association
New England Medical Center
750 Washington St., NEMC Box 271
Boston, MA 02111-1845
(508)427-3137

Resources for Cross Cultural Health Care
8915 Sudbury Road
Silver Spring, MD 20009
(301)588-6051

Asian Counseling and Referral Service
1032 S. Jackson Street, Suite 200
Seattle, WA 98104
(206)461-3606

Program in Translation and Interpreting
University of Minnesota
College of Liberal Arts
192 Klaeber Court
320 16th Avenue, S.E.
Minneapolis, MN 55455
(612)624-6552

Community Interpreter Project
Hunter College Center for the Study of Family Policy
695 Park Avenue
New York, NY 10021
(212) 772-4120

Asian Health Services
310 8th Street, Suite 200
Oakland, CA 94607-4297
(510) 465-3271

Association of Asian Pacific Community Health Organizations (AAPCHO)
1212 Broadway, Suite 730
Oakland, CA 94612-1825
(510)272-9536

The Monterey Institute of International Studies
P.O. Box 7485
Sprekels, CA 93962
(408)455-1507

The Critical Link
Community Programs Branch
Ministry of Citizenship, Culture, and Recreation
16th Floor, 77 Bloor Street. W., Toronto
Ontario M7A2R9
Canada

D. Language Working Group Participants

African Services Committee
Bellevue Hospital Center
Beth Israel Medical Center
Better Health Plan
Bronx Health Plan
Bronx Lebanon Hospital
Child Health Clinics of NYC
Chinese American Planning Council
Columbia Presbyterian Medical Center
Community Association of Progressive Dominicans
Coney Island Hospital
Elmhurst Hospital Center
Gay Men's Health Crisis
Gouverneur Diagnostic and Treatment Center
Grantmakers in Health
Health Resource Service Administration, Maternal and Child Health
H.I.P. of New York
Hunter College Center for the Study of Family Policy
Lutheran Medical Center
Managed Healthcare Systems
Maternity Infant Care Family Planning Projects/MHRA
Mayor's Office of Immigrant Affairs/Language Services
Mayor's Office of Medicaid Managed Care
Mt. Sinai Medical Center
New York City Department of Health, Bureau of Tuberculosis Control
New York Downtown Hospital
New York Immigration Coalition
Refugee Women Council
St. Vincent's Medical Center